STATE OF MONTANA

OFFICE OF THE STATE PUBLIC DEFENDER

MENTAL HEALTH PROVIDER CLAIM FOR SERVICES
CONFLICT CASES

Name of Claimant _____ Vendor ID # _____

Service Provided:

- ☐ Consultation
- ☐ Screening
- ☐ Comprehensive Evaluation
- ☐ Chemical Dependency Evaluation
- ☐ Sex Offender Evaluation
- ☐ Sentencing Options
- ☐ Fitness to Proceed
- ☐ Testimony

Claimant must attach an itemized invoice to this summary form. The invoice must detail services by assigned OPD client number and document dates, time spent, rate of pay, and a description of the activity. **Attach a copy of the pre-approval notice** for all pre-approved costs. OPD client numbers are assigned by the Regional Office. Separate summary forms must be prepared for non-conflict cases. The attorney requesting your services can direct you to the appropriate form. All travel expenses reported on this claim are to be detailed on a travel expense voucher form by case number and attached to this claim form. Claimant must submit a monthly claim by the 10th of the month following the month in which costs were incurred. **Submit this claim to the Conflict Coordinator, 44 W. Park, Butte MT 59701. Please mail the original. We cannot accept faxes.**

Month of Service _____ **Billing for Region** _____

Client Name	OPD-Assigned Case ID #	Attorney's Name	Total Fees	Total Costs (including Travel)	Total Fees & Costs
TOTALS			-	-	- -

The undersigned claimant certifies that the cases listed, expenses claimed and the times reported are true and accurate.

Claimant's Signature/Date of Submission _____ Conflict Coordinator's Approval/Date of Approval _____

Signatures above certify that all costs in excess of $200 have been pre-approved.

OPD MHC0911